STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING _____ B. WING _____	05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

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F 000	INITIAL COMMENTS An annual Recertification survey and complaint investigation #30721, #31240, and #31510, were completed on May 22, 2013, at Mayfield Rehabilitation Center. No deficiencies were cited related to complaint investigations #31240 and #31510. Deficiencies were cited related to complaint investigation #30721 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	1. The Physician of Resident # 33 was notified of the Residents current medical condition on May 22, 2013 by the unit manager. The Physician visited Resident #33 on May 23,2013 at the facility due to readmission to the facility. The nurse completed a nurse's note to reflect the care rendered on 5-19-13 and 5-20-13. The nurses were counseled related to documentation guidelines and MD notification of changes. Nursing staff educated on documentation guidelines and physician notification of changes on. 2. A facility audit of Physician orders will be completed by June 14, 2013. If the same deficient practice is observed, the Physician will be notified and a clarification of the order will be obtained.	5-30-13. 6-14-2013

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Bowers — TITLE: Administrator — (X6) DATE: 6/13/13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician of Emergency Department orders after a return from the hospital for one resident (#33) of thirty-four residents reviewed. The findings included: Resident #33 was admitted to the facility on June 29, 2010, with diagnoses including End Stage Renal Disease, Insulin Dependent Diabetes, Anemia; Anxiety, Depression, and Epilepsy. Medical record review of the electronic Medication Administration Record (e-MAR) dated May 2013, revealed "...7:28 AM, 5/19/13 Scheduled: 7:30 AM, 5/19/13...ACCUCHECK...blood sugar 41..." Medical record review of the facility electronic special situation Nurse's Notes (SBAR) dated May 19, 2013, revealed "...(the resident) was shaking, sweating, cold skin could not answer questions correctly...Resident was transported to...(name) Hospital...reported to Dr...on 5/19/13 at 5:55 PM...return call/new orders from MD...not yet" Medical record review of the (name) Medical	F 157	3. The charge nurse will review Emergency Department after care instructions for any recommendations and notify the attending Physician upon return to facility. The charge nurse will give a copy of the Emergency Department aftercare instructions to the unit manager for review to ensure recommendations were communicated to the Physician and the required documentation was completed. 4. The DON, Unit Manager, or designee will perform an audit of the medical record when a Resident returns from the Emergency Department utilizing the Emergency Department transfer audit form. The DON or designee will report findings in the monthly CQI meeting. The DON will be responsible for monitoring the process. The CQI committee consists of DON, Administrator, Physician, Dietary, Activity, Social Services, Housekeeping/Laundry, and Maintenance. Rehab Director and Nurse Unit Manager (2)	6-13-2013

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F 157	Continued From page 2 Center Emergency Department After Care Instructions dated May 19, 2013, at 8:52 p.m., revealed "Instructions for Hypoglycemia 1.You were treated for low blood sugar (hypoglycemia)...check your blood sugar every four hours for the next 24 hours. Make sure it is not getting too low...Follow up with your physician Tomorrow..." Medical record review of the Departmental Notes and eMars dated May 19, 2013, revealed no documentation of the resident's return from the hospital, no documentation of a notification of the resident's Physician, of the resident's return or condition after emergency treatment for low blood sugar, and no documentation of any monitoring of the resident's condition/status and blood sugar. Medical record review of the Departmental Notes dated May 20, 2013, at 5:26 a.m., revealed "...Resident has been having grand mal seizure for the last 10 minutes. Dr...notified. Order to send to ED." Medical record review of the hospital History and Physical dated May 20, 2013, revealed "...Admission Diagnoses: Hypoglycemia and Seizure...the patient was initially brought to the emergency room last night due to low blood sugar...the patient returned to the nursing home...the patient once again returned after having an episode of seizure. The patient was noted once again to be hypoglycemic..." Interview with Unit Manager #1 at the South Nurses Station, on May 22, 2013, at 9:30 a.m., confirmed there was no documentation of the resident's Physician being notified after the	F 157		

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F 157	Continued From page 3 resident returned from the initial ED visit and no documentation of glucose monitoring prior to the resident being transported again to the ED. Interview with the Director of Nursing, in the training room, on May 22, 2013, at 12:20 p.m., confirmed the assigned Nurse should have notified the Physician when the resident returned from the ED on May 19, 2013, to discuss the ED diagnosis, discharge instructions, and further glucose monitoring.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to provide care according to facility policy and established professional standards for two (#174, #48) of thirty-four residents reviewed. The findings included: Resident #174 was admitted to the facility on February 20, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes, Cerebral Vascular Accident with Hemiplegia, Congestive Heart Failure, and Peripheral Vascular Disease. Medical record review of Physician's Orders dated September 10, 2012, revealed an order for Norco 5-325 (pain medicine) tablet orally every 4	F 281	1. The Nurse Practioner was notified of failure to administer Fosamax 70 mg po per Physician's order in April and May 2013. The Physician's Order for Fosamax 70mg PO was clarified to include the frequency of every week on Friday and added to the Resident's active physician orders. The medication administration record and Pin flow sheet for Resident # 174 was reviewed by the Director of Nursing on 5-24-13 to evaluate accuracy of the documentation of pain flow sheet. .Nursing staff in serviced related to pain flow sheet documentation on 2. A facility audit of physician orders will be completed by June 14, 2013. If the same deficient practice is observed, The Physician will be notified and clarification of order will be obtained.	5-22-13 5-30-13 6-14-2013

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F 281	Continued From page 4 hours as needed for pain. Medical record review of the Pain Flow Sheet for October 2012 revealed Norco 5/325 mg (milligrams) was only signed out during the night and all by the same nurse. Medical record review of the electronic Medication Administration Record (eMAR) revealed Norco 5/325 mg (milligrams) was signed out on September 12, 2012, at 9:49 p.m., September 13, 2012, at 7:27 p.m., September 15, 2012, at 11:48 p.m., September 17, 2012, at 6:07 p.m., September 18, 2012, at 6:48 p.m., September 21, 2012, at 6:21 p.m., September 25, 2012, at 8:08 p.m., September 28, 2012, at 7:17 p.m., October 1, 2012, at 6:22 p.m., October 3, 2012, at 6:05 p.m., October 17, 2012, at 1:39 p.m., October 29, 2012, at 8:08 a.m., November 5, 2012, at 5:11 p.m., November 10, 2012, at 6:53 p.m., November 12, 2012, at 12:48 p.m. and 8:10 p.m., and November 16, 2012, at 1:17 p.m. Medical record review of the Pain Flow Sheet for the dates listed above revealed no documentation of the administration of Norco for the resident. Review of facility policy, Medication Administration - General Guidelines, revealed "...when prn (as needed) medications are administered the following documentation is provided: 1. date and time of administration, dose, route 2. complaints or symptoms for which the medication was given 3. results achieved from administering the dose and time results were noted 4. signature or initials of person recording	F 281	3. The Medical Records nurse will initial the physicians order after ensuring the order is correct in the electronic medical record. The unit manager will then check the electronic medical record again to ensure the physicians order is entered correctly and initial the physician's order once completed. The unit manager(s) will monitor the compliance of the documentation on the pain flow sheet by auditing 10 Residents pain flow sheet per week with comparison to the medication administration record. 4. The Director of Nursing of designee will randomly audit the accuracy of physician order entry and the pain flow sheet and report results in the monthly CQI meeting. The DON will be responsible to monitor compliance.	6-13-2013 6-21-13 6-13-2013

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F 281	Continued From page 5 administration and results Interview with the Director of Nursing on May 22, 2013, at 10 a.m., in the conference room, confirmed pain medications were not documented on the Pain Flow Sheet and staff had failed to follow the facility policy.. Resident #48 was readmitted to the facility on April 15, 2013, with diagnoses including Depressive Disorder, General Osteoarthritis and Alzheimer's Disease. Medical record review of a Physician's Order dated April 24, 2013, revealed, "Fosamax 70 mg (milligrams) po (by mouth) with full glass of water and pt (patient) must sit up for 30 minutes after taking...indication...OP (Osteoporosis)..." Medical record review of the Medication Administration Record (eMAR) for April and May 2013 revealed the Fosamax had not been administered. Medical record review of a Physician's Order dated May 22, 2013, revealed, "Fosamax 70 mg po q (every) week on Friday with full glass of water, Pt to be sitting up for 30 minutes after it is given..." Interview with Licensed Practical Nurse Unit Manager #1 on May 22, 2013, at 12:30 p.m., at the 400 hall nursing station, confirmed the April 24, 2013, Physician's Order did not indicate the frequency of medication administration, which the facility had not clarified until May 22, 2013, and the Fosamax had not been administered as	F 281		

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F 281	Continued From page 6 ordered. C/O #30721	F 281		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide showers as scheduled for one resident (#77) of thirty-four residents reviewed. The findings included: Resident #77 was admitted to the facility on June 29, 2012, with diagnoses including Anemia, Congestive Heart Failure, Dementia, and Depression. Medical record review of the quarterly Minimum Data Set dated March 6, 2013, revealed the resident had severely impaired cognition and required supervision with bathing. Medical record review of the Care Plan last reviewed March 2013 revealed the resident was to receive showers according to the shower schedule. Medical record review of the ADL (Activities of Daily Living) Assistance and Support	F 311	1. The shower schedule for Resident # 77 was reviewed by the unit manager on May 22, 2013 to ensure the day and time of the shower was accurate. A review of this Resident bathing report roster was conducted on June 10 2013 to ensure the resident is receiving assistance with bathing as scheduled. 2. A review of the bathing report roster will be completed for active Residents for the time frame of May 1st, 2013 through June7th, 2013 to ensure the facility has provided showers as scheduled. If other Residents are identified as having the same deficient practice, The Resident will be bathed if not already completed and the assigned CNA will be counseled. 3. The Charge Nurse will review the shower schedule at the beginning of the shift and assign showers to the CNA per the CNA assignment sheet. After completing assigned showers the CNA will initial the assignment sheet and the nurse will review for completion at the end of the shift to ensure showers were completed.	6-10-2013 6-14-2013 6-14-2013

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F 311	Continued From page 7 documentation and the Bathing Report Roster for April 2013 revealed the resident did not receive a shower or bath between April 4 and April 9, 2013 (six days). Observation of the resident on May 22, 2013, at 8:00 a.m., in the resident's room revealed the resident sitting on the side of the bed dressing with staff assistance. Telephone interview on May 21, 2013, at 9:06 a.m., with the resident's family member revealed the family member did not think the resident was receiving enough showers. Interview with Licensed Practical Nurse Unit Manager #2 and Certified Nursing Assistant #1 on May 22, 2013, at 12:37 p.m., in the 500 Hall day room revealed the resident was to receive showers on Mondays, Wednesdays, and Fridays. Further interview confirmed the resident did not receive a shower as scheduled on April 5 and April 8, 2013, which resulted in the resident not receiving a bath or shower for six days.	F 311	4. The Restorative Nurse will review the electronic medical record of 10 Residents per day with assigned showers (Monday-Friday) times one month to monitor compliance of shower schedule and documentation there of. After 1 month this will decrease to 5 showers per day times 1 month, then 2 showers per day times 1 month, then 30 per month there after. The DON or designee will report compliance in the monthly CQI meeting. The DON will be responsible for monitoring this process.	6-17-2013
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	1. Nursing staff educated on documentation guidelines on. 2. A review of the electronic medication administration record for current Residents receiving Nebulizer treatments will be reviewed to ensure compliance with physician orders and documentation guidelines if the same deficient practice is identified the nurse will complete an assessment of the Resident and notify the Physician of findings, Education and disciplinary action will be provided as indicated. Completed by	5-30-13 6-14-13

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F 514	Continued From page 8 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure complete medical records for one (#174) of thirty-four residents reviewed. The findings included: Resident #174 was admitted to the facility on February 20, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes, Cerbral Vascular Accident with Hemiplegia, Congestive Heart Failure, and Peripheral Vascular Disease. Medical record review of Physician's Orders dated August 28, 2012, revealed the resident was ordered Advair 250-50 Diskus one puff every 12 hours and Albuterol 0.083% inhalation solution 1 treatment via nebulizer every 4 hours while awake. Medical record review of Physician's Notes dated November 9, 2012, revealed "...nursing to administer ordered respiratory treatments as indicated." Medical ercoed review of the electronic Medication Administration Record (eMAR) for October and November 2012 revealed all scheduled doses of the Albuterol, Advair and Atrovent were documented as being administered every 4 hours.	F 514	3. As of April 11, 2013 the facility's electronic medical record reflects the information included on the Documentation of Nebulizer Treatment form, therefore the facility no longer utilizes the separate form, reducing the risk for error. 4. The DON, Unit Manager or designee will randomly monitor the documentation of Nebulizer Treatment of 10 Residents per month and report the results in the monthly CQI meeting.	4-11-13

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F 514	Continued From page 9 Medical record review of the Documentation for Nebulizer Treatment - Scheduled or prn revealed the 6:00 p.m. and 10:00 p.m. doses were not documented as administered on October 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 17, 18, 19, 22, 23, 24, 25, 26, 27, 29, 30, November 2, 3, 6, 7, 8, 9, 17, 2012. Continued medical record review of the Documentation for Nebulizer Treatment revealed no doses were documented at all on September 29, October 7, 8, 14, 21, 28, November 4 ,5,10,11, 2012. Interview with the Director of Nursing on May 22, 2013, at 10 a.m., in the conference room, confirmed documentation of respiratory treatments were not completely documented and should have been documented on the Documentation for Nebulizer Treatment form. C/O #30721	F 514		

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